

➤ Overhauling Oversight: Human Rights at the INCB

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Reform of the UN drug conventions, however desirable it may be, is probably not imminent. Governments are likely to have to live with the conventions as they are for some time. As with any legislation, the conventions come to life in the way they are interpreted and implemented. As other papers in this report have shown, there is room for varied interpretations of fundamental provisions of the drug conventions.¹

The global arbiter of interpretation and implementation of the conventions is the International Narcotics Control Board (INCB). The INCB was established by the 1961 Single Convention with the mandate ‘to limit the cultivation, production manufacture and use of drugs to an adequate amount required for medical and scientific purposes, to ensure their availability for such purposes, and to prevent illicit cultivation, production and manufacture of, and illicit trafficking in and use of, drugs.’² The INCB characterises itself as a ‘quasi-judicial’ body – a word not used in the conventions – and highlights its independence as well as that of its members.³

The drug policy reform movement in the world today does not always speak with one voice, but there is a strong consensus among many of its proponents that a goal of reform is drug policy better grounded in human rights norms as well as in the science and ethics of public health. These principles emerge from a large body of evidence suggesting that people who use drugs in many countries face systematic human rights abuse, including police abuse, and that states frequently do not give adequate priority to ensuring health services for people who use drugs. In his paper in this report, Damon Barrett makes the case that the drug conventions cannot be regarded as isolated from other international law, including human rights law. Similarly, the conventions cannot be seen to be divorced from accepted norms of public health and medical ethics. They are concerned with what is, after all, an important and neglected public health issue. The health concerns of the conventions are explicit in that they commit states to providing services to ensure ‘the early identification, treatment, education, after-care, rehabilitation and social reintegration of persons with drug dependence, as well as services designed to prevent illicit drug use.’⁴

This paper explores two key questions: (1) If the INCB were doing its job with an eye toward ensuring that drug control efforts are grounded in – or at least do not undermine – human rights and public health, what might be some features of its work that are not now present? (2) What would it take to achieve such a change?

1 For example, see William McAllister’s contribution to this report.

2 Single Convention on Narcotic Drugs, 1961, Art. 9.4 and Art. 12.5

3 See www.incb.org

4 For example, Single Convention, 1961, Art. 38

RIGHTS AND HEALTH WITH A FOCUS ON TREATMENT FOR DRUG DEPENDENCE

As noted above, the centre of the INCB's mandate is ensuring that adequate quantities of controlled substances are available for 'scientific and medical uses'. Among the most important of these uses is treatment of drug dependence itself, notably the use of opium-derived substances such as methadone and buprenorphine to treat opiate addiction. Given its treaty-mandated status, the INCB should be the world's most important promoter and protector of this use of controlled opioids. Unfortunately, this is far from the reality.

The World Health Organization (WHO), the Joint United Nations Programme on HIV/AIDS (UNAIDS) and the UN Office on Drugs and Crime (UNODC) have clearly stated that so-called substitution or maintenance therapy with methadone or buprenorphine (sometimes also called medication-assisted therapy or MAT) is well supported by decades of research.⁵ MAT is an essential element of HIV control because the medicines in question are delivered orally, thus enabling patients to avoid the harms of injection. MAT helps to stabilise people's lives, reduce crime, and enable patients to adhere to other therapies including HIV treatment. The UN position paper emphasises that continuous administration of MAT over an indefinite period is clinically indicated for some patients, and that 'weaning' MAT patients off these medicines just for the sake of abstinence is unsound.

The INCB seems to disregard these internationally accepted norms. In its annual reports, which represent virtually the only public record of its work, the Board has often sounded the alarm over fast-growing HIV epidemics linked to drug use, but has generally refused to recognise MAT as an important HIV prevention tool, as the technical UN bodies have done. Its most recent annual report, released in March 2012, for example, includes this observation:

With regard to the existing methadone substitution programmes that are being conducted in Mauritius, the Board invites the Government to increase the provision of psychosocial support and to find ways of guiding drug abusers towards reducing their drug intake so that they may eventually stop abusing drugs.⁶

The characterisation of methadone treatment as 'abusing drugs' undermines this essential therapy in a way that is exactly contrary to the mandate of the INCB.

The INCB regularly states its concern that methadone and buprenorphine (another opioid used to treat drug dependence) are likely to be diverted to illicit markets. However, it largely ignores the many examples of countries that have reliable systems of security and control for these essential medicines. Based on its annual reports and technical reports, the INCB has done nothing to urge Russia, which bans methadone, to lift that ban, or to urge countries with very limited availability to methadone therapy to expand it. INCB members, who serve as experts in their personal capacities, have in recent years included persons who have denounced methadone maintenance therapy as little better than heroin addiction or have suggested that only non-medication-assisted therapies are acceptable under the drug conventions. These views are in direct conflict both with the unanimous Declaration of Commitment on HIV/AIDS of the UN General Assembly in 2001 and with position papers of WHO, UNAIDS and UNODC recommending opiate maintenance therapy as a central element of HIV prevention.

⁵ World Health Organization, UN Office on Drugs and Crime, and Joint UN Programme on HIV/AIDS. WHO/UNODC/UNAIDS position paper, *Substitution Maintenance Therapy in the Management of Opioid Dependence and HIV/AIDS Prevention*, (Geneva: United Nations, 2004), http://whqlibdoc.who.int/unids/2004/9241591153_eng.pdf.

⁶ International Narcotics Control Board, *Annual report of the International Narcotics Control Board for 2011*, (Vienna: 2012), paragraph 106, At: <http://www.incb.org/incb/en/annual-report-2011.html>.

More recently, the INCB refused to join UNODC, WHO, UNAIDS and many other UN bodies in denouncing compulsory drug ‘treatment’ facilities that exist in a number of countries.⁷ The INCB chairman, Dr Hamid Ghodse, said at the 2012 session of the Commission on Narcotic Drugs that the INCB could not denounce such practices because it was not mandated to make such pronouncements by the terms of the drug conventions and rather had to maintain a rigorous neutrality in such matters. Ghodse also asserted that human rights is not the concern of the INCB or of the drug conventions. In the case of compulsory ‘treatment’ centres, the INCB in its report for the year 2011 effectively endorsed such centres when it encouraged the government of Vietnam – which runs one of the biggest networks of ‘treatment’ detention centres in the world – to reinforce its existing drug-control institutions.⁸

Even apart from abusive practices in treatment of drug dependence, it would be helpful if the INCB would prioritise in its work countries where health services for people who use drugs are compromised because of moral judgments and stigma they face as well as misunderstanding of the nature of drug dependence. Drug dependence affects many millions of people in the world but, compared to other health concerns, treatment to address it is particularly inaccessible to those who need it,⁹ good-quality services are rarely a national priority, and the WHO and UNODC have only recently tried to suggest minimum standards for its provision. In many countries good-quality treatment for drug addiction is completely unaffordable for those who need it. Though people who inject drugs are rightly regarded as a high-risk group for HIV, in many countries they are systematically excluded from treatment for HIV. This is in spite of evidence that they adhere to HIV treatment regimens as well as other patients do.

If the INCB were doing the job of overseeing adherence to the drug conventions in their fullness, these concerns would have high priority. Instead, the Board’s concern for treating drug dependence, and other health services for people who use drugs, seems consistently overshadowed by a scientifically unjustified bias in favour of abstinence at all costs and by support for harsh policing.

RIGHTS AND LAW ENFORCEMENT

Law enforcement practices have an enormous influence on the ability of people who use drugs to be safe and healthy and to have access to health and social services. People who use drugs are easy prey for police who need to fill arrest quotas. Police in many settings are known to target drug treatment facilities and needle exchange services to fill quotas, thus discouraging people from seeking those services. Once people who live with drug dependence are in custody, police can easily use their addiction as an instrument of coercion. Police crackdowns may lead people to inject in hidden locations where they are far from services should they experience overdose or vascular injury, and paraphernalia laws may force them to hide and share needles unsafely. In many places, seeking health services may force people who use drugs to be registered with the police even if they are otherwise not charged with a crime. The undermining influence of all of these factors on health and rights of people who use drugs has been documented in many countries in all regions of the world.

If the INCB saw its mandate in a way that included health and human rights on a par – or even anywhere on the radar screen – with law enforcement, it could be a very important voice for encouraging police and judicial practices that would protect people’s right to health services and to conditions in which they can protect themselves from deadly illness. Instead, the Board has a long history of praising countries for repressive practices that undermine access to health services and violate people’s rights.

7 UNAIDS, World Health Organization, UNICEF et al. (2012), *Joint Statement: Compulsory Drug Detention and Rehabilitation Centres*, http://www.who.int/hiv/mediacentre/joint_statement_20120308.pdf.

8 Ibid., paragraph 117.

9 Philip S. Wang et al., (2007), ‘Use of Mental Health Services for Anxiety, Mood and Substance Disorders in 17 Countries in the WHO World Mental Health Surveys,’ *Lancet* (370): 841-850.

An extreme example was the INCB's reaction to a major drug crackdown in Thailand in 2003. During this more than 2500 persons were gunned down by the state, execution-style, in the name of the 'war on drugs' even though many were later found to have little to do with drugs or to be very minor offenders. Visiting the country a few months later, the INCB noted that the action had decreased amphetamine use in the country, not commenting on the horrific cost of this result. It congratulated the government for investigating the killings at a time when civil society organisations around the world as well as some UN officials protested that the government was blocking all independent investigations.¹⁰ In 2005, when the European Commission and many human rights organisations were criticising Bulgaria for passing one of the world's most draconian drug laws by which even minor offenses could draw prison sentences of over 10 years, the INCB congratulated the country on its political commitment to addressing drug abuse.

The INCB seems to have no trouble accepting governments' justifications of repressive policing as necessary to ensure the greater collective good of public security. But the 'quasi-judicial' INCB cannot be above international law on this point. The international human rights regime recognises that there are times when the rights of individuals must be limited for the sake of public security, but the UN has established standards for judging whether countries abuse the 'public security' or 'public emergency' defence. Those standards, known as the Siracusa principles,¹¹ set out minimum conditions that states should observe when they abrogate human rights in the name of security or for emergency purposes. These principles assert that limitations of human rights in emergencies must, among other things:

- Respond to a pressing public or social need, i.e. a legitimate emergency;
- Be pursued within the limits of an emergency that is publicly declared;
- Pursue a legitimate aim and be proportionate to that aim;
- Not be arbitrary or unreasonable;
- Be consistent with national law;
- Constitute the least restrictive means possible for achieving the purpose of the limitation;
- Include complaint mechanisms and adequate remedies for those whose rights are violated; and
- Not interfere with the democratic functioning of society.

The principles include this caution:

National security may be invoked to justify measures limiting certain rights only when they are taken to protect the existence of the national or its territorial integrity or political independence against force or threat of force... The systematic violation of human rights undermines true national security and may jeopardise international peace and security. A state responsible for such violation shall not invoke national security as a justification for measures aimed at suppressing opposition to such violation or at perpetrating repressive practices against its population.¹²

One may question whether drug control should ever constitute an emergency of the kind envisioned by the Siracusa principles. But even if it does, it is incumbent on the body that oversees state practice of drug control to call upon internationally agreed standards to rein in the most abusive practices.

The INCB's unconstrained praise of repressive practices only fuels the strong temptation that countries face to use 'drug war' approaches to justify measures that may be disproportionately harsh. There is also ample evidence from many countries to suggest that drug control measures are sometimes applied in a discriminatory

¹⁰ Joanne Csete and Daniel Wolfe, *Closed to reason: the International Narcotics Control Board and HIV/AIDS* (Toronto: Canadian HIV/AIDS Legal Network/Open Society Institute, 2007), <http://www.aidslaw.ca/publications/publicationsdocEN.php?ref=672>

¹¹ Economic and Social Council of the United Nations (ECOSOC), 1984, *Siracusa Principles on the Limitation and Derogation of Provisions in the International Covenant on Civil and Political Rights*, UN Doc No E/CN.4/1984/4.

¹² *Ibid.*, paragraphs 29, 32.

way against racial or ethnic minority populations. This phenomenon is extensively documented in the United States with respect to drug arrests and incarceration of people of African and Hispanic origin. In many European countries, people of African, Caribbean, Asian and Roma origin are over-represented among persons searched, arrested and incarcerated for drug offenses. Countries may hide behind popular drug wars in pursuing racist measures that would not be as politically acceptable. Even if the measures taken in these cases are seen by society and political leaders to respond to a public emergency, the discrimination inherent in these measures raises questions about their appropriateness. The INCB does not have a record of concerning itself with these violations of basic rights.

PARTICIPATION OF CIVIL SOCIETY

In recent decades the United Nations has opened its procedures significantly to civil society participation. Virtually all major United Nations events and summits accommodate NGO forums of various kinds, and many invite NGO participation in the form of speaking slots to accredited delegates, permission to distribute publications, and space for NGO networking. The Joint United Nations Programme on HIV/AIDS (UNAIDS) includes civil society representatives on its governing body, though not as voting members. Even the UN Security Council, historically one of the UN's most secretive bodies, has opened up its proceedings. There is an officially established NGO Working Group that relates to the Security Council and is involved in regular meetings and briefings often through the vehicle of the rotating Council president.¹³

UNAIDS and its predecessor the WHO Global Programme on AIDS have been leaders in emphasising the importance of meaningful participation of people affected by HIV in UN processes concerning the epidemic. While practices are not always perfect, the principle is repeatedly articulated and explicitly includes meaningful participation of sex workers, LGBT persons, people who use drugs, and people living with HIV. UNAIDS asserts that meaningful participation of drug users, for example, in programs and policies that affect them is the only way to ensure that government responses take account of the reality of conditions in the lives of marginalised persons.

The INCB has also noted the importance of involving civil society in drug control efforts. In its 2012 report covering the year 2011, for example, it notes:

*Governments must ensure the provision of drug abuse prevention services, especially in communities experiencing social disintegration. All stakeholders – schools, community groups, parents and state and voluntary agencies – should be involved in the design and implementation of interventions aimed at achieving this goal.*¹⁴

In the same report, the Board notes that the involvement of civil society in drug control programs is crucial 'to empower the communities and promote a culture of aspiration rather than one of marginalisation.'¹⁵

In spite of such observations, the INCB remains perhaps the most closed and least transparent of any entity supported by the United Nations. There are no minutes or public reports on the deliberations of the INCB. The INCB's proceedings are closed not only to NGOs but also to member states. The country visits – on which it bases its annual reports – generally do not include meetings with civil society organisations, people who use drugs, or others affected by drug control measures. In recent years, the INCB president has met with NGOs

¹³ Security Council Report, 2007, *Security Council transparency, legitimacy and effectiveness: effort to reform Council working methods, 1993-2007*, http://www.securitycouncilreport.org/site/c.gKWLeMTIsG/b.3506555/k.DA5E/Special_Research_ReportbrSecurity_Council_Transparency_Legitimacy_and_Effectivenessbr18_October_2007_No_3.htm.

¹⁴ International Narcotics Control Board, *Annual report of the International Narcotics Control Board for 2011*, (Vienna: 2012), paragraph 50a, At: <http://www.incb.org/incb/en/annual-report-2011.html>.

¹⁵ *Ibid.*, paragraph 50d.

in one session at the annual meeting of the UN Commission on Narcotic Drugs. When questioned about the closed nature of the Board at these sessions, INCB officials have repeatedly cited security concerns and the need for confidentiality associated with sensitive drug control measures. Can it be impossible, however, for the INCB to engage with civil society if the Security Council can do so with the delicate and potentially explosive issues that it considers?

In this regard, the INCB undermines its own mission. Drug control measures, like HIV control measures, are more effective and sustainable if they are designed and implemented based on the reality of affected communities. The exclusion of civil society and of member states from its deliberations encloses the INCB in the bubble of its own reality and isolates it from voices that could help guide and improve its work. It is also completely contrary to the spirit of transparency, accountability and participation that the UN professes as a working principle.

CONCLUSIONS AND RECOMMENDATIONS

The international drug conventions' achievement of their stated goal of contributing to human health and well-being would be more likely if the conventions were implemented with attention to human rights standards and with the participation of civil society. Widely accepted human rights standards for health services and health service delivery are very pertinent to drug treatment and rehabilitation and should be built into oversight of the state adherence to the conventions. Attention to human rights standards – including the right of people who use drugs to participate meaningfully in decisions related to services meant for them and the right to mechanisms of redress when rights are violated – should be part of the obligations that states take on when they ratify the drug conventions.

There is an urgent need for the INCB as the body overseeing compliance with the conventions to take human rights seriously regarding state commitments to services for people who use drugs and the ready tendency of states to limit human rights in the name of drug control. For this to happen, a number of things must change:

- The proceedings of the INCB should be opened up to both member states and civil society organisations, as the meetings of other United Nations-supported entities are. Regular interaction with human rights organisations and member states concerned about human rights would be beneficial.
- Rules for the composition of the INCB should be amended to require that the body include reputable human rights experts among its members or that it include ex officio an expert or experts from the office of the UN High Commissioner for Human Rights. International law expertise has usually been lacking in this body of experts, though international law is at the heart of the group's mandate.
- At the very least, the INCB should make a serious effort to work into its activities the human rights guidelines recently published by UNODC.¹⁶ This guidance underscores the importance to drug control efforts of ensuring that policing and provision of health and social services to people who use drugs be conducted explicitly so as to protect and promote human rights.

It would be refreshing to read an annual report of the INCB in which the Board refrains from heaping praise on countries for repressive policies and rather encourages countries to ensure that health services for people who use drugs are humane and affordable, and drug-control strategies are rights-limiting only when there is truly no less invasive alternative. Human rights norms can help make this happen, but not if they are summarily dismissed by a body that should play a central role in espousing rights-based strategies and actions. ■

¹⁶ UN Office on Drugs and Crime, *UNODC and the promotion and protection of human rights* (Vienna, 2012), http://www.unodc.org/documents/justice-and-prison-reform/HR_paper_UNODC.pdf.